



Employee Application Form

The employee must complete the sections relevant to their application. Please note it is vital all relevant questions on this form are answered accurately and that all relevant information is disclosed.

SECTION A - Employer Details

Employer Name	<input type="text"/>
Employer Address	<input type="text"/>
	<input type="text"/>

SECTION B - Plan Selection

Programme Selected	Core <input type="checkbox"/>	Core Extra <input type="checkbox"/>	Comprehensive <input type="checkbox"/>
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SECTION C - Employee Details

Title	Mr <input type="checkbox"/>	Mrs <input type="checkbox"/>	Miss <input type="checkbox"/>	Other:	<input type="text"/>						
Forename(s)	<input type="text"/>										
Surname	<input type="text"/>										
Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Date of Birth	<input type="text" value="d"/>	<input type="text" value="d"/>	/	<input type="text" value="m"/>	<input type="text" value="m"/>	/	<input type="text" value="y"/>	<input type="text" value="y"/>
Home Country	<input type="text"/>										
Height (m)	<input type="text"/>					Weight (kg)	<input type="text"/>				
Employee Nationality	<input type="text"/>					Passport No.	<input type="text"/>				
Employee Address	<input type="text"/>										
	<input type="text"/>										
E-mail Address	<input type="text"/>										
Country of Residence	<input type="text"/>										
Elected Country (for elective medical transfer. Must be in same geographical area)	<input type="text"/>										

SECTION D - Other Applicant Details

Insert the names of your dependents that require cover at this time. If you have more than three dependents please use an additional Application Form.

Dependent 1

Forename(s)					
Surname					
Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Date of Birth	d	d / m
Place of Birth	Country:	Town/City:			m
Height (m)		Weight (kg)		y	y
Relationship to Employee					

Dependent 2

Forename(s)					
Surname					
Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Date of Birth	d	d / m
Place of Birth	Country:	Town/City:			m
Height (m)		Weight (kg)		y	y
Relationship to Employee					

Dependent 3

Forename(s)					
Surname					
Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Date of Birth	d	d / m
Place of Birth	Country:	Town/City:			m
Height (m)		Weight (kg)		y	y
Relationship to Employee					

I confirm that all dependent children live in my household, are dependent solely upon me for support, and, if aged 19 to 25, are in full-time education.

Signature of Employee		Date	d	d / m
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Name		m	m / y	y
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SECTION E - Statement of Health for Individuals Listed in this Application

Please answer YES or NO. If Yes, please specify details in the space provided on the following page. All information supplied will be treated in strict confidence. All material facts including those relating to these questions must be disclosed. Failure to do so may invalidate the policy. A material fact is information that would be likely to influence the insurer's assessment and acceptance of this Application Form. If you are in any doubt whether a fact is material then it should be disclosed.

	Employee	Dependent 1	Dependent 2	Dependent 3
Is any individual pregnant?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Are any inpatient or outpatient medical/surgical or dental procedures or oral surgery (including diagnostic testing) recommended/contemplated?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Is any individual currently taking medication?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Does any individual use tobacco products?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Has any individual been examined by or consulted with a physician or doctor or received any medical treatment in the last 5 years? (routine check ups, minor ailments (coughs and colds) of a non-chronic and non-recurring nature can be ignored)	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Has any individual ever been denied medical, dental, optical or disability coverage or been quoted anything other than standard terms for them?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>

Within the last ten years has there been any disease/impairment of or any treatment for any individual for any of the following (ignore diagnostics with negative outcome)? If Yes, please give the disease/impairment, year of onset, duration and treatment details in the space provided on the following page.

	Employee	Dependent 1	Dependent 2	Dependent 3
AIDS/HIV	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Alcoholism/Substance Abuse	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Arthritis	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Asthma	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Back/Neck/Spine	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Blood Vessels/Heart	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Bones	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Brain/Head	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Cancer	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Carpal Tunnel Syndrome	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Diabetes	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Ears/Eyes	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Epilepsy	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Gastrointestinal Disorder/Intestines	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Hereditary Disorders	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Hernia	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Immune System Disorder	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Kidney/Bladder	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Liver	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Lungs	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Mental/Nervous Disorder/Nervous System	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Paralysis	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Reproductive System Disorder	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Rheumatic Fever	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Seizures	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Sexually Transmitted Infections	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Skin	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Stroke/Blood Pressure/Hypertension	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Surgical Operation	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Thyroid	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Tumour/Growth	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Ulcer	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>

SECTION F - Statement of Oral Health (Only complete this section if your employer's plan includes Routine Healthcare)

Please indicate if there is an oral/dental condition needing treatment by an individual requesting coverage.

	Employee		Dependent 1		Dependent 2		Dependent 3	
Routine dental examination in the last year?	Y <input type="checkbox"/>	N <input type="checkbox"/>	Y <input type="checkbox"/>	N <input type="checkbox"/>	Y <input type="checkbox"/>	N <input type="checkbox"/>	Y <input type="checkbox"/>	N <input type="checkbox"/>
Any fillings needed?	Y <input type="checkbox"/>	N <input type="checkbox"/>	Y <input type="checkbox"/>	N <input type="checkbox"/>	Y <input type="checkbox"/>	N <input type="checkbox"/>	Y <input type="checkbox"/>	N <input type="checkbox"/>
Any crowns needed?	Y <input type="checkbox"/>	N <input type="checkbox"/>	Y <input type="checkbox"/>	N <input type="checkbox"/>	Y <input type="checkbox"/>	N <input type="checkbox"/>	Y <input type="checkbox"/>	N <input type="checkbox"/>
Any denture/bridgework/implant needed?	Y <input type="checkbox"/>	N <input type="checkbox"/>	Y <input type="checkbox"/>	N <input type="checkbox"/>	Y <input type="checkbox"/>	N <input type="checkbox"/>	Y <input type="checkbox"/>	N <input type="checkbox"/>
Missing teeth needing replacement?	Y <input type="checkbox"/>	N <input type="checkbox"/>	Y <input type="checkbox"/>	N <input type="checkbox"/>	Y <input type="checkbox"/>	N <input type="checkbox"/>	Y <input type="checkbox"/>	N <input type="checkbox"/>
Damaged teeth needing repair?	Y <input type="checkbox"/>	N <input type="checkbox"/>	Y <input type="checkbox"/>	N <input type="checkbox"/>	Y <input type="checkbox"/>	N <input type="checkbox"/>	Y <input type="checkbox"/>	N <input type="checkbox"/>
Gum problem needing treatment?	Y <input type="checkbox"/>	N <input type="checkbox"/>	Y <input type="checkbox"/>	N <input type="checkbox"/>	Y <input type="checkbox"/>	N <input type="checkbox"/>	Y <input type="checkbox"/>	N <input type="checkbox"/>
Root canal treatment needed?	Y <input type="checkbox"/>	N <input type="checkbox"/>	Y <input type="checkbox"/>	N <input type="checkbox"/>	Y <input type="checkbox"/>	N <input type="checkbox"/>	Y <input type="checkbox"/>	N <input type="checkbox"/>
Any teeth needing extraction?	Y <input type="checkbox"/>	N <input type="checkbox"/>	Y <input type="checkbox"/>	N <input type="checkbox"/>	Y <input type="checkbox"/>	N <input type="checkbox"/>	Y <input type="checkbox"/>	N <input type="checkbox"/>
Periodontal disease needing treatment?	Y <input type="checkbox"/>	N <input type="checkbox"/>	Y <input type="checkbox"/>	N <input type="checkbox"/>	Y <input type="checkbox"/>	N <input type="checkbox"/>	Y <input type="checkbox"/>	N <input type="checkbox"/>
Orthodontic treatment needed?	Y <input type="checkbox"/>	N <input type="checkbox"/>	Y <input type="checkbox"/>	N <input type="checkbox"/>	Y <input type="checkbox"/>	N <input type="checkbox"/>	Y <input type="checkbox"/>	N <input type="checkbox"/>

Use this space to complete extra information required for Section E or F. Continue on a separate sheet of paper if there is insufficient space.

SECTION G - Banking Details (For reimbursement of any claims)

Currency of Account	Pound Sterling £ <input type="checkbox"/> USD \$ <input type="checkbox"/> Euro € <input type="checkbox"/> Other: <input type="text"/>			
Name of Bank	<input type="text"/>			
Address	<input type="text"/>			
	<input type="text"/>			
Postcode	<input type="text"/>	Country	<input type="text"/>	
Account Number	<input type="text"/>	Sort Code	<input type="text"/>	
IBAN Number	<input type="text"/>			

SECTION H - Data Protection

LAMP Insurance Company Limited assures you that all your personal and medical information will be held in strictest confidence and in accordance with applicable legislation. Personal data may be passed to other companies with the LAMP Group or given to third party providers in relation to services which we provide to you, and may be transferred by electronic or other means. You have a right to know what information is held about you, and to amend or delete any data we hold which is inaccurate or out-of-date.

SECTION I - Certification by Employee and Spouse (if Spouse coverage is required)

- I/We certify that these answers are complete and true to the best of my knowledge and belief. I will inform LAMP Insurance Company Limited of any changes to the information provided which happen between the time the form is completed and the time coverage becomes effective. I agree that this document shall form a part of my request for group coverage and I acknowledge that I have been given a copy of this document as completed by me.
- I/We understand that, to the extent permitted by law, false statements will result in the denial of claims or in my insurance coverage being void and the premium forfeit with no benefits payable. I understand that conditions which are disclosed on this form will be subject to all conditions of my employer's Plan, including specifically any pre-existing medical condition limitations and exclusions.
- I, the employee, and (if in employment) I, the spouse, certify that I am actively at work, meaning that I am employed and have not been absent from work through sickness, illness or injury for more than ten days in the last year and that, at the date of signing this certification, I have not been absent from work through sickness, illness or injury at all in the last month. I, the spouse, (if not in employment) certify that I have not been sick, ill or injured for more than ten days in the last year.
- My signature indicates that I have reviewed all information and statements on this form for accuracy and completeness.
- **AUTHORISATION:** To all physicians/hospitals/healthcare institutions/insurers/medical or hospital service providers/employers: You are authorised to provide LAMP Insurance Company Limited information concerning healthcare, advice, treatment, supplies, absence (including those related to mental illness and/or AIDS/ARC/HIV) relating to me or any members of my family for whom coverage has been requested. This information will be used to determine eligibility for coverage. This authorisation will be valid for twenty four months from the date of signature of this form.
- I/We acknowledge that I/We will reinstate this authorisation after twenty four months have passed if so requested by LAMP Insurance Company Limited.
- I agree that a facsimile or scanned copy of this authorisation is as valid as the original.
- I **WISH/DO NOT WISH** (*delete as appropriate*), at my expense, to see any copies of any reports obtained using this authorisation **BEFORE/AFTER** (*delete as appropriate*) they are sent to LAMP Insurance Company Limited.

Signature of Employee

Date

 / /

Name

Signature of Spouse

Date

 / /

Name

Please return this questionnaire to your broker/intermediary, or to:

Healthcare Underwriting Department
LAMP Insurance Company Limited
260/262 Main Street
Gibraltar

Email: healthcare@lampinsurance.com

LAMP Insurance Company Limited, 260/262 Main Street, Gibraltar
Tel: +350 20051904

LAMP Insurance Company Limited is licensed by the Chief Executive of the
Financial Services Commission of Gibraltar under the Insurance Companies Ordinance.
Registered Address: 260/262 Main Street, Gibraltar
Company Number: 93562
Email: info@lampinsurance.com
Web: www.lampinsurance.com